VA Geriatrics and Gerontology Advisory Committee
April 4-5, 2006

Participants:

Full members
- Itamar Abrass, M.D., Chair
- Norman Abeles, Ph.D.
- Adrian Atizado
- Robert Carbonneau
- Joann Damron-Rodriguez, L.C.S.W., Ph.D.
- John Derr, R.Ph.
- Teresa Dolan, D.D.S., M.P.H.
- Terry Fulmer, PhD., R.N., F.A.A.N.
- Jade Gong, R.N., M.P.P.M.
- Mary Jane Koren, M.D., M.P.H.
- Richard Veith, M.D.

Ex-Officio members
- Judith Salerno, M.D., M.S.

Members excused
- Margaret Giannini, M.D. (Ex-Officio)
- Michael O'Rourke
- Tom Yoshikawa, M.D.

Guests
- Madhulika Agarwal, M.D. (Chief Officer, Patient Care Services)
- Joe Francis, M.D., M.P.H. (Acting Deputy Chief, Office of Research and Development)
- Christa Hojlo, D.N.Sc. (Office of Geriatrics and Extended Care)
- Joy Hunter (Employee Education System)
- Michael J. Kussman, M.D., M.S. (Principal Deputy Under Secretary for Health)
- Alec Petkoff (American Legion)
- Randy Taylor, Ph.D. (Employee Education System)

Staff
- James Burris, M.D.
- Susan Cooley, Ph. D. (via telephone)
- Marcia Holt-Delaney
- Kenneth Shay, D.D.S., M.S.

Dr. Abrass welcomed members of the committee to the meeting and began the business by introducing the GGAC's newest member, Teresa (Terri) Dolan, Dean of the University of Florida College of Dentistry in Gainesville, Florida. He then reviewed the agenda and noted that his appointment to speak with Drs. Perlin and Kussman in the afternoon would not be including Dr. Perlin; however he and Dr. Burris would meet with Dr. Kussman; after which they would meet with Dr. Agarwal. He also noted that Dr. Kussman would be attending the GGAC meeting prior to the meeting with Drs. Abrass and Burris. As such, Dr. Abrass encouraged GGAC members to raise questions concerning the White Paper with the PDUSH. The major topic areas Dr. Abrass plans on covering in his discussion

with Dr. Kussman include the White Paper itself; the completeness of data collected from the GEC Referral; educational loan repayment eligibility by VA trainees; GRECC funding; and the comparability of Non-Institutional Care and Care Coordination Home Tele-health (CCHT) workload.

He also noted that the Executive Decision Memo concerning GRECC funding had been reviewed unofficially by Dr. Perlin and Dr. Kussman. As a result of this Dr. Agarwal was directed to develop a report concerning the funding, activities, and productivity of GRECCs, MIRECCs, and PADRECCs. This has not yet been completed. However, Dr. Abrass was looking forward to discussing its progress with Dr. Agarwal.

He then invited Dr. Shay to update the group on the progress of the White Paper. Dr. Shay noted that a delay had occurred because the original document was initially (late October) not logged into the VACO mail system. When this was discovered, in late January, a rapid turnaround for a response was requested by the Under Secretary, whose office referred the report back to the Office of GEC for a response before sending the report forward to the Office of the Secretary. Later in the concurrence process the Office of the White House Liaison insisted that a more detailed response (i.e., point-by-point response to the recommendations in the Paper) was required from the Office of the Under Secretary. As a result, the report has gone up and down in the hierarchy several times. At present, it is awaiting a signature by the Secretary. Dr. Abrass clarified for participants that the nature of GGAC reports is that, as a courtesy, they are furnished to the Department prior to being sent to the Congress. VA may not modify the paper but it may add comments in its cover letter to the Congress. He stressed that at all times the focus of the advisory group, as it strives to provide useful input to the Secretary, is to maintain cordial relationships with the Department and never to embarrass either the Secretary or the Under Secretary.

A number of GGAC members asked for an explanation from Dr. Burris as to what would transpire when the report had moved from the Secretary's Office to the Congress. Dr. Burris characterized subsequent action as falling into one of three categories. The report could prompt a question directed at the Department, in which case the Office of GEC (and probably Dr. Shay) would need to draft a response for the Department. A second option would be that the report would prompt an actual hearing on the part of one or both Congressional Committees, in which case the Office of GEC (and probably Dr. Shay) would need to develop responses to testimony furnished by witnesses called by the committee(s). The third possibility would be the development of legislation, in which case the Department, directed by the Congress, would develop the legislation, probably through the efforts of the Office of GEC (likely delegated to Dr. Shay).

Dr. Dolan inquired as to what would be necessary to change the mechanism for GRECC funding. Dr. Abrass clarified that funding for the GRECC is an internal VHA matter, and not currently specified through the legislative process. As such, modifying the existing policy employs the use of an "Executive Decision Memorandum", wherein the initiating office (in this case, Geriatrics and Extended Care) develops a background statement of the problem, identifies the factors bearing on the issue, proposes several potential decisions stemming from the issue, lists advantages and disadvantages for each option, and then offers a recommendation. Ultimately, the choice is made and the decision memo signed by the Under Secretary for Health. Under the current leadership system in VHA, the National Leadership Board, consisting of all 21 VISN Directors and a number of Program Office Directors, reviews the decision memo and makes its own recommendation

to the USH. It is up to Dr. Perlin whether he goes along with the NLB recommendation, goes along with the recommended option, goes along with another option in the memo, or develops an option of his own. Dr. Abrass reminded the group that the recommended choice in the current decision memo under consideration, that of recentralizing GRECC funding, had been suggested by Dr. Kussman in response to the request by GGAC that he sign a renewal of the original memorandum to the VISNs from the then-Deputy Under Secretary for Health, reminding them of their obligation to promptly fill GRECC vacancies; or failing that, to either freeze or eliminate those vacancies only after the review and with the approval, of the USH.

In reviewing the White Paper, Mr. Carbonneau pointed out that the final recommendation in the version that went forward to the Secretary for comment was questionable: it specifies that the Congress should give priorities to VHA if resources are inadequate, but this is a double edged sword. Dr. Fulmer and Ms. Gong clarified that this recommendation had been placed in the paper because of the different constituencies that were affected when funding was inadequate; and that veterans of different backgrounds were thereby significantly disadvantaged by decisions that had to be made by the Department that was responsible for their care. Mr. Carbonneau responded that alternatives to the existing system deserve to be part of the recommendation, and Dr. Abrass noted that the White Paper consists of many such alternatives. He also stressed that the White Paper was not intended to be the final word, but rather to initiate discourse with lawmakers, hopefully leading to more concrete solutions. Dr. Abeles asked whether the report would go to the Select Committee on Aging; it was clarified for his benefit that it goes to the House and Senate Veterans Committees.

Ms. Gong wondered whether it might be worthwhile to offer to the Secretary of Veterans Affairs a briefing on the paper. Dr. Abrass countered that the paper dealt with VHA issues, and therefore made most sense at the Under Secretary level. Dr. Shay said that the cover letter to the report from Dr. Abrass invited the possibility of a briefing if the Secretary were interested. Dr. Burris clarified that, as advisory to both the Secretary and the Congress, it would be entirely within Dr. Abrass's right, as Chair of the Advisory Committee, to request a briefing. Dr. Abrass noted that he was aware of this but was hoping that the process, as it had been proceeding so far, would end up with satisfactory results.

Dr. Burris: VHA Strategic Planning

Dr. Burris began by stating that the Secretary of Veterans Affairs, James Nicholson, initiated a strategic planning process when he joined the Department in February 2005. Following the setting of his strategic priorities, the three VA agencies (NCA, VBA, and VHA) each initiated a similar process. He reminded the group that there had been 21 strategies under Dr. Kizer; 12 under Dr. Garthwaite; and 12 while Dr. Perlin was acting. Now that Dr. Perlin has been confirmed in his position (also in the spring 2005) he is focusing those original 12 into 8. Dr. Burris went through the "Eight for Excellence" and noted that strategic initiative 1.5 is specific for aging veterans. A total of 25 initiatives have been put forward by the Office of Geriatrics and Extended Care. These are actively tracked; quarterly reports on the progress of several are furnished to Patient Care Services. He then provided details on the four most carefully scrutinized strategic initiatives:

Cultural Transformation: Nursing homes have become more focused on disease management than being person-centered institutions. Dr. Hojlo, from whom the group would hear later in the meeting, has initiated and is driving a system-wide transformation,

directed at completely changing the environment of care in nursing homes. This involves some environmental changes, but largely changes in healthcare workforce, educational needs, new policies and directives.

Increase access to Non-institutional Care, including CCHT: This process has been a major focus since the Millennium Act of 1999. It reflects the recognition that people prefer to age within familiar environments, and stresses alternatives to extended care that permit individuals to remain in their homes. The General Accountability Office (GAO) report on Post-Mill Act progress toward development in Non-Institutional Care found major gaps in VHA's accomplishments. A recent follow-up noted improvement but saw additional opportunities for enhancement. Currently, VHA is only addressing about a quarter of the demand in Non-Institutional Services. Some of what VA provides is through contracted relationships (e.g. hospice, skilled home care, Contracted Adult Day Healthcare); as such, limited access occurs when such services are neither close by a VA nor available in the community.

A major thrust within this second initiative is continued growth in Hospice and Palliative Care services. A national survey is being undertaken to assess H&PC capacity. In addition, a H&PC satisfaction survey has been under development and review by the Office of Management and Budget as are all surveys that are going to be sent to greater than 100 citizens. Mr. Atizado asked for clarification: was Dr. Burris referring to the "bereavement survey"? The answer was affirmative: the major objection to the request for permission to conduct a pilot was on the basis of sensitivity to survivors who had recently lost a loved one.

The GRECCs' short, intermediate, and long range plans that dovetail with VHA's: Dr. Burris noted that the Summary Annual Report continues to show a strong return on investment, over 50 FTE of clinical contribution, research that more than pays for itself, and strong educational programs. Mr. Derr asked for clarification regarding the ROI: he noted that the community expects geriatric expertise from VA; could this not be counted as well? Dr Shay clarified that the ROI which has been communicated to VHA management tries, whenever appropriate, to be as quantitative as possible. Dr. Abrass did concur however that the retention rate of trainees in VHA is quite high. Dr. Salerno noted that historically this had been tracked in the GEC Office, and found to be quite high. Dr. Shay will contact her for details to see whether this can be revisited.

Dr. Burris continued to speak on the topic of GRECC contributions and an enhanced awareness of them on the part of the system. He noted that at the VISN level, there is generally great interest in GRECCs providing training. He noted that enhanced interaction among the AD/EE of the GRECC has occurred. In collaboration with GRECCs, Dr. Edes and Dr. Cooley have developed a number of training experiences in dementia, delirium, and end of life care. Dr. Abrass has been an observer to the process of performance measure revisions on the part of the GRECCs. He noted that a long standing accusation of GRECCs was that they were insufficinetly involved with their parent medical centers and/or VISNs. As such, it has been an important focus of Dr. Shay to work toward aligning the revised performance measures with visible VHA and VISN strategic initiatives and expectations.

Care Coordination Home Tele-health: This is largely in the office run by Dr. Darkins. However, there continue to be proactive efforts to keep CCHT well coordinated with other extended care efforts.

Dr. Veith asked Dr. Burris if GEC had particular strategic priorities within these initiatives. Dr. Burris reiterated the different initiatives, stressing that all were very important but that the four that he had described seemed to be particularly amenable for demonstrating positive progress in the course of the year.

Cultural Transformation

Dr. Hojlo spoke to the group in more detail about the "Cultural Transformation" that she is undertaking to address major shortcomings in institutional extended care in VHA and VA related programs. She noted that nursing homes had become places to avoid. Her own education in this topic had been largely informed by the Pioneer Network which has adopted a proactive, humanistic stance designed to make nursing homes desirable places to recuperate, live, and work. There have been attempts for several decades to enhance the nursing home environment, such as OBRA, the Coalition for Nursing Home Reform, and CMS standards. CMS itself is now embracing some of the principles of the Pioneer Network.

Central to a transformation is a clear understanding of the desired end. Dr. Hojlo offered a new, working definition of "what is a nursing home" which focused on the dynamism of the services, consistency with other care oversight programs, relative medical and psychiatric stability of patients, services that are of uniform quality (regardless of the duration of stay), and a focus on residents' needs rather than medical care processes. She related a number of anecdotes highlighting the relative unpleasantness of an existence in a nursing home, and how subtle and overt environmental cues, including rigidly enforced schedules, minimal patient choice, and dehumanizing treatment of patients, undermine goals of care and preservation of human dignity. She noted that recreation in nursing homes has traditionally consisted of "Bible, Bingo, and birthdays" and this is inadequate. She spoke of the importance of redefining spaces within the nursing home: a patient's room is rather termed a bedroom, clarifying the expectation that little more than sleep is done there, and that other activities occur in other parts of the facilities. She stressed the importance of giving names to different units, in order to foster a sense of community and uniqueness. She noted that she and her collaborators are in discussion and undertaking activities with CMS, CARF, and the American Association of Homes and Services for the Aged. She stressed that VA is one of the leaders in this movement.

A number of GGAC members inquired as to human resources issues: much of what is suggested would seem to require additional staffing, and how likely is that in light of the minimal margins under which most LTC facilites operate? Dr. Hojlo acknowledged this, and admitted that currently the VA staffing standards, while higher than the community, are considerably below what would be optimal in this environment. Mr. Derr expressed his support for the concept, but stressed that the 70% of community nursing homes that are for profit in fact have margins of 2% or less. With nearly 82% of their incomes being attributed to Medicare, their ability to increase their revenue stream and thereby raise nurse staffing ratios is extremely limited.

Other questions were raised about staffing. Dr. Hojlo emphasized that the current model for nursing homes has an RN as the manager of each unit, and yet there is no particular reason for this to be so. Similarly, facilities do not need to limit the delivery of food trays to just nurse aides. In the "transformed" nursing home, social workers, physicians, and ward staff would participate in meals. Mr. Derr inquired whether VA has adopted the "feeding assistance program"; Dr. Hojlo acknowledged that VHA encourages volunteers to eat with

patients; this should be expanded to paid staff as well. Significant staffing considerations were once again discussed in regards to patients arising at different hours, requiring vastly different foods for meals, etc. Dr. Hojlo stressed that the vision she had described was an ideal, and stressed that many VAs, seeking that ideal, have made significant changes. There have been negotiations with the unions, and the relaxation of certain stringent facility environmental rules.

Dr. Hojlo noted that a factor on which success for her project was dependent involved being careful about who is admitted to a VA nursing home. With growth in Non-Institutional Care, those who can remain and thrive in the community should do so. She noted that there are three key questions to ask before admitting an individual to a nursing home:

1. Why is this person here [what services are required]?
2. For how long [focus on timeliness of care]?
3. Where will this individual go when #2 has been completed [initiation of discharge plan upon admission]?

Dr. Hojlo noted that this program within VHA started approximately one year ago, when 250 people, representing all 21 VISNs and in many cases interdisciplinary teams from given sites, convened for a cultural transformation summit. The emphasis at that meeting had been on empowerment, and involvement from all levels of the healthcare organization. Since that time, cultural transformation Points Of Contact (POCs) have participated in monthly calls, during which they share what they are doing. Several VA NHCUs are now certified as "Edenized", although Dr. Bill Thomas's "Eden" program is not specifically advocated. Finally, Dr. Hojlo and members of her team perform unannounced site visits in a process similar to CMS, employing standards drawn from JCAHO. An exit interview with frontline staff and top management sets the stage for the initiation of necessary change. The site visit team does not stop its activities upon leaving the particular facility, but conducts follow up phone calls and visits.

Members inquired as to the resources necessary to make this transformation occur. Dr. Hojlo stressed that a bigger part of the transformation was "internal" and that properly motivated, work staff so impress management that resources are forthcoming. Dr. Damron-Rodriguez congratulated Dr. Hojlo on her efforts. She stressed the wonderful opportunities that this transformation offers medical and other allied health trainees.

GRECC Performance 2005

Dr. Shay presented the latest in his three year series on GRECC performance, going back to FY'99. Employing data from the GRECC electronic database and VA's fiscal system, Dr. Shay shared that the total expense of the GRECC program in "direct costs" was now slightly over $37 million for the 21 programs. He noted that the total number of FTE is approximately stable or up slightly since 2004, presently at 282. Of greater concern is the sustained number and importance of key vacancies in the GRECCs. He reviewed the mixture of Director, Associate Director, and Administrative Officer vacancies. There are over 41 vacant FTE as of March 28, representing 50 positions. The average duration that these positions are open exceeds 34 months. Several of the Associate Director vacancies have been open for seven years or longer; and several Administrative Officer positions have been open for greater than four years.

Despite the staffing challenges, the GRECCs continue to show very productive research activity. In 2005 total GRECC-reported research expenditures were over $101 million. As he has done in prior years, Dr. Shay then explored how this research productivity, as

accounted for in the VERA allocation methodology, compared to the costs of the GRECCs. He demonstrated that, because of a smaller Congressional allocation for VA research in 2005, the GRECCs as a system actually accounted for less VERA allocation than they cost in direct costs: $35 million versus $37 million. Five GRECCs continue to have research productivity that exceeds their local direct costs; however the number of GRECCs that in 2005 represented more in personnel costs than their VERA allocation, due to research productivity, continues to rise. He noted that another measure of research productivity, the number of publications, was actually down in 2005 from slightly over 1000 down to a figure of 899. He speculated some of this might be due to more accurate reporting.

Nevertheless Dr. Veith insisted that an overly harsh judgment was being made about the GRECCs. He noted that from a "return on investment" point of view, the GRECCs were an amazing academic investment: for an investment of $35 million, VHA got 50 clinical FTE, 900 publications, $100 million of research funding (of which $77 million came from outside VHA) plus all of the expertise recruited into the GRECCs.

Dr. Shay also reported that over $13 million in education funding was expended by GRECCs in 2005. Dr. Damron-Rodriguez asked whether it was reasonable to assume that the majority of this was funding for Geriatric Education Centers through the Bureau of Health Professions. Dr. Shay admitted this was probably the case, but stressed that a sizeable amount of funding was independent of this mechanism. He also noted that 17 of the 20 individual GRECC programs had received education funding in 2005.

Discussion by the committee focused on potential leveraging of GRECC-derived publications. Dr. Shay acknowledged that Dr. Cooley has instituted an innovative means to assist the GRECCs in reporting their publications, and even scholarly scientific presentations, in advance, per Office of Research and Development (ORD) policy. This information, as it makes its way into the GRECC database, is also being rolled up in Dr. Shay's office. Mr. Foley, Dr. Shay's secretary, has expressed interest in pursuing a means by which, in time, this listing of articles by GRECC personnel could serve as a means for disseminating that information to those who are interested. The question was raised whether there might be copyright issues, but Dr. Shay stressed that even if only the abstracts and the full reference information were made available, this still would be a terrific asset. Dr. Damron-Rodriguez concurred that this sounded extremely appealing but stressed that a project of this magnitude would require dedicated staff support. Dr. Veith suggested that the concept should not be limited to just published articles, but that GRECC faculty producing educational materials should similarly have their products catalogued and made accessible. Dr. Shay responded that he and Mr. Foley have been working with the AD/EE for over a year to compile just this information, and this project is nearing completion, in anticipation for trying to integrate that information with the EES Learning Catalogue.

Dementia Initiatives

Dr. Cooley told the group of her activities under the Third GEC Strategic Initiative (not one of those individually tracked, as described earlier by Dr. Burris), concerning the continuum of care, the multidisciplinary, tele-health, and partnership-leveraged activities in educating the workforce on management of the patient with a dementing illness. She described the dementia registry she has been working on for several years that will populate information tables of administrative data including demography, services provided, costs, etc. It will soon be available on the ARC website and is broken down by different diagnostic codes

for the different varieties of dementia. In addition, there are also data tables which are extremely useful and informative. She gave the example of FY'03 data on the prevalence of different dementing illnesses; outpatient service use broken down by different services and age groups; and costs, also by age and different programs. She clarified that the data came from the outpatient and inpatient treatment files, and information bases that are used for third party billing, and as such are fully compliant with CMS standards.

Another activity on which VHA is working on behalf of patients with dementia concerns collaborations with CCHT. Susan is working with the Office of Care Coordination to identify Home Tele-health programs focusing on dementia in order to share lessons learned throughout the field. Speakers have to date been identified from Miami, Salt Lake City, San Francisco, Lexington, Buffalo/Albany, Togas, Bronx, and Coatesville. The next step of this initiative will be to employ that expertise in one or more learning experiences.

Dr. Cooley spoke of dementia safety, specifically access to firearms and driving. She recently discussed a new idea concerning reporting requirements and VHA obligations with the Chief Medical Officers. A voluntary annual reporting template has been suggested. In addition, her workgroup on this topic has recommended that VISNs consider developing clinical reminders to prompt clinicians to include these considerations in their assessment of suitable patients. The workgroup had a total of 18 items that they are making available across the system to facilitate implementation of this: policies, clinical reminders, etc.

Dr. Cooley is also engaged in education focusing on dementia. Another workgroup has been conducting a review of available dementia education training materials both inside and outside of VA. They're identifying characteristics, topics, whether or not the training includes evaluations or have been evaluated; as well as costs. They are developing an annotated bibliography and a format for surveying the field, particularly GRECCs, with respect to the materials that are developed. Once the complete list has been developed, the workgroup will evaluate the information covered for gaps remaining, and make recommendations as to whether VA should develop these or whether they might be available to buy. Most recently there have been a number of successful activities in education on dementia. Four satellite training programs have been converted into CDN format for on demand desktop viewing. Training on dementia recognition by primary care providers, two of the AHEAD programs, and the FDA Advisory on A-typical Antipsychotics are now going to be made available to broader audiences through these efforts.

Principal Deputy Undersecretary for Health Michael J. Kussman, M.D., M.S.

Dr. Kussman thanked GGAC for inviting him to speak with them again. Before sharing his information and taking questions from the group he congratulated Dr. Dolan for her appointment to the GGAC and presented her with a certificate from Mr. Nicholson, Secretary of Veterans Affairs.

Dr. Kussman began by discussing VHAs budget. He noted there are still unsettled issues concerning the FY'06 budget, largely stemming from four different "pots" of money in which VHA receives its allocation. VA is actually solvent, but the funding for Administrative Activities is deficient while there are excess funds in the other "pots".

He spoke optimistically about FY'07. He noted that if the proposals under consideration are fully funded, it will be a "good year". Some of this will depend on the success of collections: an increase of 9-11% over FY'06 was projected. He noted that VA did very

well: only the Departments of Defense, Homeland Security, and VA got increases over FY'06. He also noted that part of the original proposal had included an increase of enrollment fee and copays that would have enhanced resources by approximately $1 billion. For a variety of reasons, this was dropped from the budget, although Tri-Care, CMS, and other large payers have found it necessary to take on these measures.

He then spoke about information technology. He noted that there was a movement afoot to centralize information technology within VA. Currently, VHA, VBA, and NCA each has its own IT system. By centralizing, all three systems have to have a common platform; but this essentially means that the healthcare-related innovations of VHA will have to be understood by non-healthcare people charged with running the full IT system. Dr. Kussman characterized IT within VHA as more than "just IT": he stressed that the healthcare record and the adjunctive decision support system capabilities of IT in VHA make the IT architecture an essential component of the healthcare system. A second issue with information technology is that there is pressure, particularly from the House of Representatives Oversight Committee, to enhance "transparency" in IT decisions within VHA. Some of this is attributable to a major project failure in VISN 8, "CORE FLS"- - which really was a VA, not a VHA, undertaking.

Dr. Kussman then turned to discussion of GRECC funding. He acknowledged that there was reason to feel that GRECCs were being under-funded because of their support through VERA. He acknowledged that MIRECCs and PADRECCs are still carve outs and speculated that one approach might be for those two programs to become decentralized as well. Because of the magnitude of the cost, and the desire on the part of VISN Directors to maintain as much control as possible over as many resources as possible, this is a delicate procedure. He noted that he has been "pushing on it" but that there has been significant push back. There are two forms of proposals at hand; one, the Executive Decision Memo, suggesting recentralization from a policy standpoint; and two, a suggestion to authorize a $44 million expenditure as part of the projections for FY'07 specific purpose funds. While he acknowledged that recentralizing GRECC support would involve resources of that magnitude, he noted that identifying $44 million to take out of the VERA allocation would be an extremely difficult proposition.

Dr. Veith offered his "return on investment" argument to Dr. Kussman: $35 million expense for over $77 million of extramural funding, 1000 publications, $13 million of education funding, 50 FTEE, as well as incalculable worth in expertise and health professional education. His conclusion is that the GRECC research is driving multiple other activities, and that it not only pays for itself but in fact generates additional resources. Dr. Kussman countered that the problem was that VHA, at its heart, is a healthcare organization, and sees this expenditure as for the 50 clinical FTE – which is not a bargain for $35 million. The key, he said, is showing value added. He continued with an example of the current thrust for Non-Institutional Care as an alternative to traditional nursing homes. He noted that there was considerable push-back from State Veterans Homes, a relatively powerful lobby. Dollars spent on Non-Institutional Care ends up undercutting institutional resources. VA pays approximately 65% of the bill to build State Veterans Homes, and 35% of their operating costs. Movements in favor of what is unquestionably a better and more rational treatment choice nevertheless have their opponents.

Dr. Salerno asked Dr. Kussman to speculate on a timeframe over which this GRECC funding issue might be resolved. She pointed out that it had been in deliberation since

1996 or before; now there is this decision memorandum and a proposal: what was a likely timeframe? Dr. Kussman was unable to suggest with any accuracy a likely timeframe but speculated it would be on the order of months at best.

Discussion reverted back to the State Veterans Homes and their role with Non-Institutional Care. Ms. Gong noted that currently there are restrictions against State Veterans Homes providing Non-Institutional Care, however, if those could be addressed, might that not attract their interest to support VHA's Non-Institutional Care programs? Dr. Salerno noted that in the past the resistance to State Veterans Homes being involved in Non-Institutional Care was based on Medicare standards. Ms. Gong pointed out that, in contrast to what Dr. Salerno had said about the historic reluctance to address Medicare standards, many State Veterans Homes now are compliant with Medicare certification. Mr. Atizado pointed out that VA currently contracts for more than $2 billion worth of care and there is a strong will to rein that in; presumably this would work counter to Ms. Gong's suggestion. She countered that Contract Nursing Homes and other contractors don't know or understand vets, but that State Veterans Homes have a very different agenda. Mr. Atizado pointed out that another impediment was the absence of full access to the electronic record. Dr. Burris clarified that State Veterans Homes have "read only" access to the electronic record. Dr. Kussman stressed that when working on a system wide basis, small efficiencies add up to millions of dollars. He gave the example of increasing the discharge efficiency in Intensive Care Units and how millions of dollars can be saved through more timely discharges.

Discussion then turned back to the GRECCs. Membership discussed with Dr. Kussman the compelling arguments in favor of GRECCs. He offered no disagreement with any of them, but continued to stress the political sensitivity of the situation. Members thought it important to have "compelling stories" that would prove convincing to the VISN Directors. Dr. Salerno pointed out the need for convincing clinical demonstrations that offer superior ways of accomplishing challenges. Dr. Veith gave the example of a recent Kaiser/UCLA collaboration, involving treatment of depression in which an innovative approach that was better, more effective, and less costly was available for broader dissemination. When innovations such as that have been identified, and the GRECC can put its stamp on them, this has to be brought to the awareness of top VA management.

Dr. Abrass stressed that it was expected that the VISN Directors and the VAMC Directors would not support recentralizing GRECC funding. Their challenges are to adequately staff and direct safe healthcare systems in the face of finite resources. When they have multiple vacancies, they have to select from among them those which will best suit their short term needs. If a decision has to be made between a GRECC Administrative Officer and a Cardiac Care Nurse, the decision is neither difficult nor in favor of the GRECC. He stated his point repeatedly that, as long as the decision for filling vacancies rests with the VISN or the VAMC, the GRECC will have to lose, until such time as resources are in excess. For this reason, recentralization, or at least a reinforced will on the part of VHA leadership to address vacancies in a timely fashion, was requisite.

GRECC Site Visits

Dr. Abrass introduced the group to the St. Louis site visit, conducted in August 2005. He reviewed the letter of response from the VAMC Director, which addressed each of the recommendations provided by GGAC. Both he and GGAC members found the response letter fairly vague and slightly unsatisfactory. As such, Dr. Abrass directed Dr. Shay to

develop a response which would, to each proposed solution to each recommendation, ask for some level of documentation or other indication of positive movement.

- For the recommendation which concerned the lack of communication of GRECC activity to VISN leadership the letter back to the site will request minutes of GRECC-level meetings indicating that this information has been shared and discussed.
- The recommendation for enhanced clinical dissemination of successful models will be countered with a request for a progress report on grants submitted or Letters Of Intent drafted to that end.
- The progress on dividing up the responsibilities of the Associate Chief of Staff for Education (ACOS/E) and the ACOS for Research, currently fulfilled by a single individual, will similarly be requested in the form of top-level discussions, minutes, communications, etc.
- The inadequately multidisciplinary character of the Advisory Board will be addressed by requesting copies of that group's minutes.
- Progress in growing a Geropsychiatry presence at the medical center will similarly be assessed through examination of clinical experiences that trainees in that discipline undergo.

The Gainesville GRECC was next discussed. Because of some emerging personnel issues that had been unofficially shared with Dr. Shay, and the sensitivity of them, GGAC went onto executive session, excusing Mr. Petkoff temporarily. Dr. Shay and Dr. Abrass will continue to be in contact with Gainesville leadership and any action in regards to the Gainesville GRECC's response to the GGAC visit of last summer will be on hold until the current situation plays out.

GGAC has yet to receive a response from the West Los Angeles site visit report, which was due in late December, but was delayed because West Los Angles leadership recognized the complexity and the delicacy of the situation, and, in conjunction with Mr. Clark, the VISN Director, opted to appoint an Advisory Committee to examine the issue. Shortly after this was relayed to Dr. Shay, the intention of furnishing the report prior to the work of the Advisory Committee was communicated. Yet the report is still being held up at the level of the Chief of Staff and his deputy Dr. Mahler. Members of the committee suggested that the pace at which this issue was being addressed, and the multiple forces playing on it, were indicative of many of the same elements responsible for the situation there. Dr. Abrass expressed his disappointment: in August, the Chief of Staff seemed genuinely committed to addressing this issue in a timely manner, and GRECC leadership seemed extremely open to the points that were being raised and suggestions that were made in August. However, shortly after this, the GRECC Director had written a long note to Dr. Shay and Dr. Abrass essentially contradicting many of the observations that the site visit team had made and had shared with him. Judgment will be suspended until the actual report is received, but Dr. Abrass is very concerned that the Los Angeles issue will not achieve resolution in the timeframe looked for.

Dr. Abrass reminded the group that close to three years ago the Minneapolis GRECC had been site visited and a recommendation made to immediately fill the AO position. Local management had agreed to do this; there were a number of follow up progress reports, and progress was extremely slow. The position was finally approved at an appropriate grade level this fall, but has not been approved to fill. A letter was written to the Director who essentially dismissed the request on the very grounds that Dr. Abrass described earlier in this meeting: in the face of daunting clinical demands, a non-clinical position

must take a low priority. Dr. Shay shared that he had discussed the situation with the Care Line Manager for VISN 23, who offered to bring it to the attention of the VISN Director. However, the Care Line Manager's opinion was that the VISN Director would back the Medical Center Director on this, both in terms of needing to support the clinical mission, and also from the standpoint of employee moral: how would it be perceived in the event that a clinical service remained understaffed even as the GRECC received its full administrative level of support.

Dr. Abrass reviewed plans for the upcoming GRECC site visits:

- April 20: Madison (Abrass, Koren, Derr, Veith- Burris staffing)
- May 10: San Antonio (Abrass, Yoshikawa, Derr- Shay staffing)
- June 5: Durham (Abrass, Damron-Rodriguez, Abeles- Shay staffing)

Review of Meeting with Top VHA Management

Dr. Abrass reported early on the second day of the meeting that his discussion with Drs. Burris and Kussman the evening before had gone very well. The PDUSH was very receptive to everything that was raised and again reiterated that the major impediment was resistance on the part of VISNs. When Dr. Abrass subsequently met with Dr. Agarwal, it was pointed out that the original EDM had not included the "Kizer memo" option that a strongly worded reminder to the VISNs, reiterating their responsibility to fill positions or request they be eliminated subject to USH approval, be reissued. It is not clear whether this is an option that either Dr. Kussman or Dr. Perlin is interested in, but unquestionably this will be more attractive to the VISNs. Dr. Dolan inquired as to who would mediate the standoff that might ensue, and received the answer that the decision ultimately was Dr. Perlin's. Dr. Shay inquired whether the inclusion of the "Kizer memo" option would then eliminate any consideration of the need for predictable support for education and clinical demonstration activity. Dr. Abrass offered his opinion that this is a separate issue and that the first order of business was to ensure GRECC support. He directed Dr. Shay to amend the decision memorandum as discussed and append to it an updated version of the "Kizer memo".

Chief Officer, Patient Care Services

Dr. Agarwal introduced herself to the group. She has been in VACO for two years, following a career as an internist and the Associate Chief of Staff for Ambulatory Care at the Washington D.C. VAMC. She was previously the Chief Consultant for Primary Care as well as Medical Surgical Care. Her intention was to share the Patient Care Services Strategic Plan with GGAC to help foster the group's understanding of the large number and complex interrelationships of programs in PCS.

She noted that when Dr. Perlin was initially the acting USH he devoted his first year to "twelve for twelve", which were largely a bridge between the programs of his predecessor, and the agenda he would ultimately adopt. That agenda is now in place as "eight for eight". It is essentially the same as the twelve but with some consolidations, and some increased emphasis, among the original number. Dr. Agarwal began by reviewing the organizational chart for Patient Care Services and clarifying how GEC related to mental health, spinal cord injury, and CCHT. She also stressed that, while each individual program has its own offices and sets of priorities, there were overarching issues as well and these figured into the strategic plan. She reviewed the vision, the mission, and the operating principles for PCS which stress a full continuum of care, leadership, interdisciplinary services, aligned goals, advocacy, and excellent customer service. Before going into details on her strategic plan, she also provided a very thought provoking result

of a strategic planning discussion among PCS leadership conducted in the summer of 2005. She had requested the participants to envision the healthcare system some years in the future. Initially, there was a great deal of focus on the IT system but Dr. Agarwal made a very clear contrast between an IT system which essentially does what paper does electronically; and an IT system that allows for greater functionality and new, unexplored roles. Once this “out of the box” thinking had been triggered, a number of emergent directions were offered by PCS staff. Care in the future will be much more patient centric and involve much more patient self management. There will be continued movement of care away from the medical center. The healthcare system will be seamless regardless of geography, and access will be flexible. The demographics of the patient population will change. There will be both more older, and sicker patients; but also younger, and female patients. Finally there will be a need for improved efficiencies through automation which will increase roles, responsibilities, and flexible work distribution. Many emergent issues with residency training, such as the need for continuity clinics that include females, will rise to the fore. In addition, there are emerging biomedical technologies concerning prevention, genomics, new pharmaceuticals, population based information giving rise to evidence based guidelines, etc. Finally, the future will see increasing demands for highly specialized services such as mental health, spinal cord injury, rehabilitation, and prosthetics.

Dr. Dolan inquired of Dr. Agarwal whether Dental Care could be considered a “specialized service”. She pointed out the increasing recognition of the role that dentistry plays in overall health and disease, and inquired about how there could be a continuum of care absent some provision for oral health. Dr. Agarwal acknowledged that dental was a “special care”, but not necessarily a ”specialized service”. Part of this is complicated by a congressional statute which limits provision of services to certain classes of veterans. However, in light of recent OEF/OIF priorities, there has been new infusions of resources both to reduce the wait time for care of those eligible for dentistry, and to support the dental needs of recently discharged veterans.

Dr. Agarwal then began to focus on some of the major initiatives including Intensive Care Unit quality of care, Poly-trauma Centers, and the very ambitious Mental Health Strategic Care Plan with its 235 recommendations. She briefly mentioned Geriatrics and Extended Care, which Dr. Burris had previously discussed. She spoke about care coordination and home tele-health, and the importance of integrating that into Advanced Clinic Access. She spoke of partnerships with the community on such projects as obesity, diabetes, and in particular the partnership with DOD/DHHS termed “MOVE”. She concluded by pointing out some of the cross cutting issues that she had noted were independent of individual stovepipes: barriers to care/access, evidence based practice, recruitment and retention, data integrity, patient centered care, national accreditation/privileging, and the corporate role of VHA.

Acting Deputy Chief Research and Development Officer

Joe Francis, M.D., MPH, addressed the group on behalf of Dr. Joel Kupersmith, Director of ORD. Dr. Francis noted that his background was in general internal medicine and boards in geriatrics. He had served from 2000-2004 in a marketing and educational role for a non-profit healthcare organization in Indiana, and expressed his delight at returning to the VA where financial considerations, while important, did not drive him to the sorts of decisions that he was forced to make in the private sector. He initially returned to VHA as the Director of QUERI, an integrated clinical, educational, and research program of HSR&D in which end users identify critical needs for research, which then are quickly

assigned to research teams who can address the issue, test emergent methodologies and hypotheses, and produce a worthwhile result in real time. It is this bridging of the gap between the research and clinical which most intrigues Dr. Francis and is, he believes, what is most important for the inclusion and survival of research within VHA.

The first topic he discussed was “genomics” which he characterized as “personalized healthcare”. He gave the example of hundreds of thousands of specimens of banked tissue which in turn could be correlated with longitudinal health outcomes in a huge system like VHA. In time, this could lead to different evidence-based decisions customized for each person. He noted for instance that over $300 million a year are spent treating adverse drug effects. If this could be diminished by only 5% this alone would pay for the $15 million genomic initiative. If, through tissue banking and prospective longitudinal analyses of outcomes, those particularly susceptible to certain adverse outcomes could avoid that the savings could readily be achieved. He noted that there were many ethical problems associated with this kind of research. He is intending to have a designated genomics center and hopes that can become part of how care is delivered within the VA.

The second topic he addressed was “QUERI” which he noted was another example of the sort of successful collaboration embodied in GRECCs, MIRECCs, and their interactions with the Office of Quality and Performance, and Patient Care Services. He expressed the opinion that these programs owe their success to being driven by needs of healthcare providers, and they operate within a “system” that isn’t merely a lab but also has patient populations that can both inform the need for developments and also test them.

He noted that the QUERI program is highly cost effective, with each center accounting for approximately $350,000 in expenses per year but leveraging many times that in grant support. He gave the example of OEF patients, screened for depression, who had not been provided psychiatric care prior to them committing suicide. In a very short period of time, once the issue had been identified, a QUERI group was pulled together to address this issue. In collaboration with Lisa Rubenstein of the Sepulveda VA they came up with an intervention that is now slated for system-wide rollout.

Dr. Francis is very interested in launching a QUERI concerning long term care: to look at young versus old in that system. With OIF veterans returning, caregivers are now parents rather than spouses or children. How does this change the paradigm? He seeks to come up with more evidence-based protocols for care. He has recently put the proposal into the National Leadership Board and is optimistic he will know soon.

He gave the third example of returning National Guard veterans, many of whom are in their forties and fifties. He noted that this cohort ensured that “new veterans” were not going to be exclusively young. And yet they are very different from “old veterans” in that they are internet savvy, impatient; yet because of their ages they have large numbers of very severe comorbidities, both acute and chronic.

He noted that the tactical approach to research on such a short timeframe was extremely challenging for non-research reasons. For instance, multi-site trials historically involve individual IRBs: yet not all IRBs are in agreement as to protocol. This is a huge “dissatisfier”. As such, he has a team working on a national IRB: not to usurp local control but to facilitate broader studies, thereby reducing redundant effort and leveraging resources. In the same way HIPPA and other privacy concerns, along with research review, all provide resistance to using the medical record for research, and yet the VA

believes they have excellent privacy restrictions and untapped reserves for valuable decision making. VA has conducted cooperative studies at multiple sites for decades, and has historically used site visits to affirm privacy. Dr. Francis is optimistic that a reduction in paperwork and redundant effort is possible if mechanisms are put into place that will affirm privacy without the current cumbersome assurance process.

He also noted that the Office of Research and Development continues to operate in an understaffed capacity. Several years ago there was a large emigration of personnel out of ORD which was not entirely bad: biomedical research, clinical research, health services, and rehabilitation had become their own “feudal centers”. Now, under new management, he and Dr. Kupersmith are asking their staff to look across the biomedical spectrum. He gave as an example the selection of to which study section a particular proposal is referred for review? This is a very salient issue in aging. He noted that great efforts are expended on behalf of every proposal to match the approach to an appropriate review group. He acknowledged that it would never be perfect but that they are always hoping for improvements.

He also reiterated ORD’s support for the Research Career Development Award process. He characterized this as a “common platform across all services for career level awardees”. He noted it is a top recruiting tool and results in very productive career pathways.

Dr. Francis said that NIH currently has a grant proposal process with a more advanced mechanism than currently is employed by ORD. Furthermore, they are looking to streamline it to an even greater extent. To that end, Dr. Francis is in discussion with the NIH to develop a memorandum of understanding to have a shared process. This will give one point access to all federal grants, thereby avoiding duplication, identifying collaborations, and easing the identification of reviewers.

He then brought up the topic of notification for publications by VA investigators. He stressed how important this was and received reassurances that the GRECC program has a number of reminder mechanisms in place, not the least of which are monthly tele-conferences with the Associate Directors for Research, but also a recently released mechanism for early notification of impending publication which is immediately transmitted to the Public Affairs Office of ORD. Dr. Francis noted that the Office of Management and Budget specifically look at publications as they are reported in PubMed. ORD is trying to develop its own publication management system and Dr. Francis stressed that if a publication was supported or conducted by a VA investigator, there should be open access to it. He speculated this may require access to a pre-publication manuscript. He also clarified that the reason VHA insists on pre-publication notification is not to censure anything, but rather an attempt to optimize publicity flowing from a positive research accomplishment, and sometimes to influence policy when a study identifies need for improvement.

His final comments concerned the budget. The current VHA research budget is $412 million; adjusted for inflation for 2007 this would be $428 million. And yet because of congressional earmarks for programs that lawmakers perceive as demanded by the populace, there are pressures forcing that level of support to diminish. He gave the example of approximately $1 billion spent on Gulf War Syndrome, and a commitment of 20% of research funding to be spent specifically on mental health related issues. He suggested to GGAC that strong input from the GRECCs would be a useful adjunct to

ensure ongoing support for aging related research, and requested any guidance that might be helpful. Dr. Abrass extended the invitation for him to participate in GRECC site visits. He graciously expressed his interest, and noted that he had just recently been at both the Pittsburgh and the Durham GRECCs. He and Dr. Kupersmith are attempting to visit all sites as soon as possible. He noted that the expenditures on VA research are very small compared to the complete federal research enterprise, and yet VA researchers account for approximately 20% of authors. Again he stressed that much of this is because of the sophistication of the medical records systems, the academic affiliations, and the coincident research and clinical programs.

He concluded by letting the group know that he is actively pursuing the concept of performance measurement for research. This would reflect activities, notification, dissemination, and use; not just counting research publications. He noted that even sites that don't actively do original research reflect on research activities elsewhere in the organization through the conduct of demonstration programs. He believes that this is an original concept in the U.S.; the Canadian Health Services Research Foundation is looking at it as well. He continued to provide examples of how population based research was so critical, and how without it, "guidelines" can be as destructive as helpful. He gave as an example the issue of compelling screening for colon cancer in patients regardless of age. A second example was cited at the Ann Arbor Health Services Research program, in which at extremely high ages, diastolic and systolic blood pressures regarded as elevated are not only not an indication for treatment, but may be necessary to prevent falls. As such, increasing evidence on the widest array and variety of patients is essential.

Mr. Atizado raised the question of how to honestly report distribution of effort within ORD to the Congress. Dr. Francis acknowledged that there were "different ways to carve out the pie" depending on what was being discussed. He provided a useful thought exercise of a multidimensional "cube" where there were axes for age along which different age groups might be carved out, axes for disease along which different diseases might be carved out, and axes for site of care along which different clinical programs could be carved out. In this way, in response to congressional questions, ORD would be able to characterize what portion of their budget is given over to one or another sort of research endeavor, but always with respect to a particular axis.

VHA Chief Learning Officer

Joy Hunter, Dean of VA Learning University, was introduced; and in turn introduced the Chief of EES Field Operations, Dr. Randy Taylor. She acknowledged her gratitude at having been invited to address GGAC and stressed how stakeholder/customer relations is the single most important guiding principle within EES. She stated the EES mission as being customer-based, accessible, and customer service-focused. She stressed that while EES serves VHA (which has the largest number of VA employees), EES has now become a VA departmental asset as well. This has raised some interesting challenges and has provided her program with many opportunities to capitalize on cutting edge learning technologies. She identified her critical success factors and how they have modified in time with what EES does. EES has always been "customer centered" and yet the lines are now blurred, as the customer may be health care employees, non-health care employees, and even the veterans themselves. It has always been "learner-focused" and yet now the learners are not all clinicians and learning takes place not exclusively in a dark room with a large number of people but often through a desktop or an I-pod in an automobile.

One critical success factor that she raised was “strategic alignment”. She stressed that EES initially had “tried to be everything to everyone” but had realized it had neither the resources nor the expertise to do this. As such the service has focused on developing client relationships with the different program offices and in that way to make the best use of the resources at hand. She also pointed out the merits in the “Employee Education Resources Centers (EERCs),” a series of geographically dispersed centers, each aligned with certain strategic plan priorities. The one in Northport, New York is assigned to geriatrics and extended care.

More contemporary critical success factors include “linking training to results”, “seeking alternative solutions to merely offering training”, and “using evaluation to ascertain what educational intervention will have the biggest effect” (i.e., doing a root cause analysis before jumping to a conclusion on what is needed). She acknowledged that these approaches are likely very time intensive on the front end, and yet yield much more effective outcomes.

The next critical success factor is “leveraging resources”. EES, like all VHA divisions, must be an organizational steward of resources. As such, information flow is essential in order to not repeat what has been done before.

The final critical success factor is “business acumen”, which flows from the need to leverage resources. It also requires that EES be invested in Return On Investment thinking: looking at results and comparing it to the costs of business.

Ms. Hunter then proceeded to describe in more detail a number of different activities and initiatives underway. She spoke of a performance consultant who had been engaged on behalf of the VHA Program Offices for one year. Addressing the recurring question of “how do I repurpose what I am doing to be in line with the strategic plan?” the performance consultant has proven an invaluable asset.

EES has been key in supporting veterans outreach. This is an example of a non-VHA, but rather VA activity. Employing its extensive array of media centers, EES has served as the production side in VA’s drive to keep new veterans informed of their rights and benefits. They have developed a number of video presentations targeted to recent dischargees on topics of benefits, changes in eligibility, etc. These in turn are broadcast on the Pentagon channel, on flights returning from the Middle East, on community cable. Dr. Damron-Rodriguez inquired why these were not as apparent in the public sector, such as network television, senior centers, etc., and not just television: how about print brochures? Dr. Taylor clarified that a careful line had to be walked so that VA was not perceived as competing with the private sector. This was perceived as some of the advantage in focusing on returning veterans who can targeted before they even reach their communities.

Ms. Hunter then spoke of a number of collaborative efforts in which EES is involved. One concerns education and training through the Department and Defense. She noted that the web-based EES Learning Catalogue was made accessible to DOD and that a Joint Educational Council exists with DOD to provide community education outreach. She offered to bring examples should she be invited to address this group again in the future. She also noted that EES works as a partner with ORD in facilitating research and development. Answering questions such as “How does one make learning possible?”, “How does one move learning from the classroom to within the workplace, and still assign

value to continuing education units?", "What kinds of environments can be created that foster learning best?", she gave the example of Learning Exchange Centers in VISN 10 which are mobile environments that foster free exchange, creativity, and exploration of new ideas. She spoke of the Content Distribution Network which soon will be replacing satellites as a means for providing real time, and also on demand, learning at the desktop. Shortly, use of CDN technology will be able to be tracked so that any program sent out immediately provides its producers with demographics of who is watching, how they are distributed, and other characteristics. She again offered to demonstrate this emergent technology to GGAC at some future time.

She spoke of VA Learning Online (VALO). She stressed that this is largely off the shelf content that has been customized for VA, but Dr. Taylor noted that he will be working in the immediate future to supplement this broad array of learning capabilities with abundant clinical opportunities as well. VBA is currently highly involved in veteran education programs through VALO.

Ms. Hunter then acknowledged that web-based learning has the potential for being very boring: how does one keep it interesting? Engaging? Interactive? In its worst form, web-based learning is a "page turner"- meaning each screen is simply a page from a book. But one of the EES staff in Birmingham is exploring ways to integrate design into websites to optimize learning through video segments in response to questions and answers, both correct and incorrect. Dr. Taylor noted that the challenge for many of these technologies is the timing and the bandwith. He noted that every 15 minutes of VA-wide mandatory training represents 28 FTEE for one year. As such, it is EES's obligation to ensure that mandatory trainings make the most of employees' time and are worthwhile. Several GGAC members inquired about means for real time access to the broad array of educational programs, as well as awarding of continuing education credits. Dr. Taylor and Ms. Hunter clarified that they believe that VHA may be the largest accrediting agency in the country. As such, they are under obligation to adhere very strictly to accepted, discipline-specific criteria. Nonetheless, they are able to do so and with appropriate controls for documenting participation and gain of competency from educational programs, continuing education credit is a possibility.

They spoke of Learning Management Systems (LMS) which is an integrated system through which participation in learning is tracked. In addition, the system will actively "market" certain programs, particularly those which are mandatory, those that help employees with their own identified learning plans, and those which advance national priorities. LMS will also permit a national roll up of information on skills, competency, use, performance. Ms. Hunter characterized it as a "portable electronic training record" that will travel with an employee even after that individual has left VHA.

Ms. Hunter concluded by acknowledging that there were three particular geriatric "touch points" that EES employs to ensure that they are addressing the needs of the Geriatrics and Extended Care priorities of VHA.

- First of these is the EERC at Northport, at which Rivkah Lindenfeld is charged with assisting Dr. Burris in PCS Strategy 1.5 regarding management of older veterans. She acknowledged the particular contributions of Rivkah's superior, Bill Greaf, who is new in his role as the supervisor at Northport and has had to grapple with a large number of vacancies. Nevertheless, she provided an impressive list of programs produced by Northport 2005-2006.

- Secondly she acknowledged the efforts of the GRECC/EES Partnership Council, co-chaired by Dr. Shay and Dr. Lindenfeld. She acknowledged that the steady parade of changes effecting EES made it important to have a forum that permits GRECC educators to keep informed of all the opportunities and particulars involved in interacting with EES. The council has been in operation fir approximately three years; and the last eighteen months have been particularly effective in refining fund transfer protocols, familiarizing GRECCs with EES programs, and familiarizing EES with what GRECC has to offer. Currently, Dr. Shay and Dr. Lindenfeld are undertaking a strategic planning process with the group to help it refocus its energies and/or take on a more passive role until such time as greater activity is called for.
- As the third touch point she acknowledged Dr. Shay's membership on the Integrated Advisory Council, the "field advisory group" for EES, which is a way to guarantee a geriatric perspective weighs in on EES decisions. She also noted that the Integrated Advisory Council reports directly to the Human Resources committee of the National Leadership Board, and therefore does help dictate the overall course of VHA.

A few closing questions were posed by GGAC. Dr. Shay inquired as to what was involved in employing podcasts/MP3 technology as a means for sustaining audio and video learning opportunities. Dr. Taylor responded that a huge volume of information can be stored in this way and that currently EES is in discussion with Mr. Kolodner of Information Technology on that very question.

Closing Comments

Dr. Abrass concluded the meeting by touching on final points:

- First, he reiterated the need to add choices regarding the "Kizer memo" to the Executive Decision Memorandum.
- He also reiterated a point that Dr. Kussman had made both to the group at large and to Dr. Abrass in private. Specifically, Secretary Nicholson apparently was quite disturbed at some negative feedback from the families of patients receiving poly-trauma treatment. He clarified for members not familiar with the concept of poly-trauma that the Middle East war has resulted in some very severe injuries of a type not seen before in which the heart, lungs, and kidneys are spared damage, but there is head trauma and the loss of one or more limbs. Clearly psychological and psychiatric trauma plays into this as well. Functionality is a major component but so are learning and behavior. Dr. Kussman clearly feels a very strong need to leverage whatever resources VHA has, in non-traditional manners if necessary, on behalf of these patients. Dr. Abrass suggested that GGAC and the GRECCs needed to give serious consideration to what expertise they can bring to bear on these issues. Discussion followed which noted that geriatrics has a great deal in common with many of the issues dealt with in poly-trauma centers: integration with family needs, interdisciplinary management, rehabilitation, modification of living space and customization of immediate environment to enhance and optimize disabled patient's ability to address their own needs, etc. Dr. Shay noted that May 16-18 was a GRECC Directors meeting in conjunction with the National Leadership in Geriatrics and Extended Care. Dr. Barbara Sigford, National Chief Consultant for Physical Medicine and Rehabilitation, will be one of the speakers and will be addressing poly-trauma and providing tours of the Minneapolis Poly-trauma Center. Dr. Shay offered to contact GRECC Directors in close geographic proximity and/or with compelling research interest that could conceivably contribute to the fulfilling of the poly-trauma centers' clinical missions.

Dr. Abrass reminded the Committee that the next meeting will be September 19-20. He adjourned the meeting.